Meeting minutes
Working group to Reinvent Medicaid

I. Welcome from the Chairs:
   a. Dennis Keefe: Fraud Waste and Abuse, Transparency, Alignment of Medicaid with State Plans. Introduces the buckets of process around initiatives,
   b. Ira Wilson: Open meetings, public town halls, comments suggestions proposals from the website. At this time we have more than 175 suggestions, and indeed even last night more suggestions were coming in which is tremendous. As Dennis noted we have broken into four work streams, behavioral health, delivery system reform, high utilizers and long term care. They have all happened before and after the normal work day and on top of the work that others are doing anyway. The goal is to continue this process today, thank Deloitte who is facilitating this conversation, donating their time today. Open, fair, reasonable public discussion of so many things about such a complex topic, fortunately Deloitte knows all about how to do that. We continue to look for open feedback about the proposals you all will hear about. In particular areas of fact, or errors in thinking that we do not know about, please jump in, please correct. We have eight days to finish and make substantive recommendations. A lot of process and dialogue passed, and more to come in this home stretch. We are asking a lot of providers to consider cuts, which will not hurt Medicaid patients who are among the most disempowered of our system. We appreciate the spirit of collaboration and community work that we are all doing this with. Health care in RI is really quite good – but it needs to be great. I hope that we all can participate in these discussions in that sense. With that said, we are going to se

II. Facilitated Discussion of Proposed Initiatives
   a. Three quotes read by Deloitte as frame setting:
      i. "RI has the second highest per enrollee (Medicaid) cost of any state in the country which is 60 percent higher than the national average" Gina Raimondo, Governor
      ii. "the health of people is really the foundation upon which all their powers as a state defend" Benjamin Disraeli, British Prime Minister
      iii. Good humor is the health of the soul – Lord Chesterfield, British politician.
   b. Objectives today: Align on definition and impacts of the critical Medicaid FY2016 initiatives; gather feedback on opportunities and challenges associated with initiatives; align on next steps
   c. Encourage all to be present, to be honest
   d. Plan of the day: describe the initiatives, then share some ideas with each other about those initiatives, and from those look for themes that the state can take forward. Then repeat.

e. Today we will go through fifty five initiatives and we have two hours – so we will go uncomfortably fast. That is okay. You will have some additional time after this meeting to get back to the Secretary's office, but be prepared that we will note have a chance to really hit all the nitty gritty you may wish to on each item.
f. The full lit of the initiatives has been distributed to the working group and after this meeting we will put it on the website for everyone to see.
g. Context: Deidre Gifford: before we start talking about some of the initiatives, I want to provide context with what we have been hearing from the public and the initiatives. The first thing is that the initiatives for FY16 are a blend to meet the budgetary imperative that we have. Set the ground work for longer term set of broader reforms. Highlight a couple of themes coming out: elimination of duplicative programs and streamline those around FFS and managed care. To consolidate services around the member; we continue to pay for some of our services through the FFS delivery system. One of the major themes is around developing accountable entities. Bringing services in plan, building structures within the Medicaid program in the medium to long term. Focusing on behavioral health plan, social services and focusing on highest utilizing highest need members. Walk through some specific initiatives.
h. Ice breaker.
i. Handed out iPad to the Working Group, will be collected again at the end of the meeting. This will allow us to download input from you all simultaneously.
j. The proposed FY16 initiatives were run though. PDF of all feedback available at : http://reinventingmedicaid.ri.gov/events/2015/4/29/reinventing-medicaid-working-group-meeting-3
k. Questions to each responded to below:
    i. Dennis Keefe: Response to questions Item 1- Reduction in the cost would require less services to be provided. The idea is to reduce unnecessary care. The better we do, all the hospitals do with meaningful reform the better the results.
    ii. Initiative #D002 – Change needs to happen fast, customize for RI populations will be very key. The initial comments here were not to have just cost savings but a better program, and this is one of those items in line with that type of thinking. What kind of care should be delivered? Improving health care while saving money.
    iii. Initiative #C001. [Same structure, full risk as hospital approach]. Feedback: Quality metrics need to be implemented for coordination of care in least expensive setting. In Wisconsin did with three acuity assessments to help implement. Bringing nursing homes to the table as bring in quality metrics. New

way of doing business, but the idea of regular assessment, collecting data, right care, right time, right person. Also, the idea here is not earning the money back but people in the least restrictive setting where they are the most comfortable and get better care, should result in a lower Medicaid cost. May require mid-course corrections over time, but a good move forward.

iv. Process note: All ideas are being captured, will be given back, and staff will use in this final stage. Specific factual questions will try to be responded to by staff, those that challenge the basis of these initiatives we will reach out to discuss. All feedback though made public.

v. Initiative #A120. Where will EOHHS get funds to support? Deidre Gifford: this is an example of a place to invest in order to save – just like investing in primary care and community health times, we will need to spend some dollars on new services in order to achieve savings. The funds will be allocated in our budget with the understanding that it will cut down on spending in the long term. The individuals who have unstable housing tend to not use primary care services, few services other than the Emergency Room, they tend to have exacerbations in health issues because of their access to care. Appropriate use of primary care, more consistent pharmacological therapies, controlling chronic conditions. CMS approval? It is in the 1115 waiver, but will need approval.

vi. Initiative #A120: At 730am tomorrow morning the High Utilizer group is going to meet and one of the main agenda items it to understand the business plans of the programs we have heard about. Until we crunch the numbers and tell us to expand, it's hard to know; A few items of feedback: complex, high cost need. Looking to integrate that care, behavioral health, acute care, things states are looking at around the country. Can we repurpose LTC beds - that is a question being raised here in our feedback loop.

vii. Initiative #A103: Questions about relationship between Community Mental Health organizations and Federally Qualified Health Centers (FQHC): one of our FQHC's now has built their own community health team, all high volume care providers have access to this service. Outcomes thus far? Our health plan partners have been looking at results and seen positive signals from those we have been able to contact. Lots of anecdotes of those who had fallen through the crack sand are now being found. Effective mechanism. Our two in CTC are all payer, so there is at least the opportunity to continue to build that as an all payer structure. Dr. Barajas: will there also be hospital based things that will follow the patient throughout

the community? Deidre Gifford: one of the primary areas of focus for the community health team will be around that transition out of a hospital. Use CurrentCare and hospital alerts there.

viii. Initiative #A103 Feedback: A few mentioned neighboring states this is happening, but we don't see a lot of data is because it is happening everywhere and it is not coordinated. To Dr. Gifford's point, look at it, bring the structure together bring the training together, have better data. Yet another initiative that is great and let's see what happens but without the structure to get started you can't see the total value. This is the roots.

ix. Initiative #B001 & Initiative #B142: Children's behavioral health care needs are key, are the dollars going into the FFS for children's behavioral health care needs shift in plan? Yes that is correct. Management and coordination optimized, all resulting in modest savings for the programs.

x. Initiative #B001& Initiative #B142 : capacity of MCOs to take on this challenge. Also, clear that this is the most liked idea we have seen, supported, but can it be implemented in a way that it is evaluated later to ensure it is a true success.

xi. Initiative #E120 Feedback: If savings assumed up front? Savings driven by utilization of high end services, cost neutral to CMHCs. Only for adults but there are similar designs in the system for children, we hope to inform that design. The non FQHC primary care will be involved, has a care coordination elements for all primary care providers in the program. In Iowa we had 20, who were in the population, a care coordination fee paid to the provider, meaningfully engage with the care coordination team. Rates and contractual expectations managed for this population, functions like a product since the benefit design is so different.

xii. Overall Question for fraud, waste, abuse category: Making the most effective use of the staff that we have, aligned with HP in Warwick, hire the staff that have experience, pre-analytic review. Feel as we go forward can get a better sense of tech, but right now existing staff is expected to do. Residency requirements: has a lot to do with the intent to reside in the state, a more difficult concept, but in theory you can collect benefits from RI and not yet be in the state. Need to tighten the policy a bit but within the confines of constitutional due process. Does Electronic Visit Verification cover all CNAs in the personal choice program? There is a task for together to get a comprehensive plan to incorporate as many as possible; who will pay for that device – we would expect that the person delivery the care would have a mobile device – that has been

the expectation in other states where it has been developed. There are places in RI that are not ideal cell phone coverage, will be transponders in those instances, $15 per transponder, paid for by the state where necessary. Process for verifying or standard: two pieces looking to see whether standards for defining residence for Medicaid eligibility are correct on par with neighboring states. Then the second is using data from claims submitted to see if there are people who are RI residents who receive most of the services out of state to verify their eligibility.

xiii. Can look to other states, predictive modeling can go with a consultant group or a software purchase to determine how to pull the data together. A lot of insight and a lot of work to get deeper into it. Talk a lot about beneficiary fraud, also provider fraud to be aware of. BCBSRI invests tens of thousand dollars a year in a fraud unit and they end up raking back millions each year to prevent this. Be sure enough investment to reap proper savings.

xiv. The hospice initiative (Initiative #F159): will be taking a little group off table, hopefully Matt Trimble, Hugh and other to ensure the numbers are on target. Feedback: MOLST make it mandatory if possible; expand ICI to include behavioral health; LTC facilities align nursing homes and hospitals; everyone is positive about PACE.

xv. What areas for short-term savings are not on the list today that should be? (All feedback from Deloitte to be recorded and returned [see link above] – highlights: one of the fascinating things is that a deadline induced wave of initiatives has come in during the past day or so some major proposals from providers that we need to review. We have received over 200 suggestions, we have focused on feasibility. Short term goals by April 30, long term goals in July.

xvi. What one thing are you personally committed to moving this forward? A lot of comments around advocacy, listening, communication. Assessment, and also collaboration, working with new partners on these ideas.

III. Public Comment: The Secretary thanked everyone, acknowledging that it is very different than our usual manner of

a. Jim McNulty: Exec director of mental health advocates of RI, "I want to thank everyone for serving on the panel. Without having had access to all of the documents, I would suggest more opening for advocacy from the community in the implementation phase. A lot of the ideas I have seen here today, and I like. The feedback from my members is whiplash with clients receiving services, no understanding on behalf of providers with new changes, and a lot of confusion there – please be aware. I would also like to make a point of commenting on peer

services – important in all areas of health care, in primary care it is key, in mental health we provide peer services, that is something I encourage this panel to look into. This is a lot of work, implementation will be difficult, and I would like to continue to be involved and will support the process as long as it keeps heading in the right direction."

b. Tina Spears, RIPIN, "Would like to echo comments about consumer advocacy in the implementation phase. Specifically with children's special health care needs, be sure not to prohibit access to care in these new phases. Caring for the child in the community requires infrastructure, are accessible, moving them in plan be thoughtful about that. Also would like to address that in RI not a strong palliative care program, I feel that should be looked at in this reform, and integrating it with our primary care community. Finally please be sure to build up primary care structure. "
c. Kathy McKeon, Catholic Diocese of Providence, "Wish to speak to three set comments, primarily elders or adults with disabilities, sent in written comments on diocesan respite. Not currently Medicaid funded but who comes into the Medicaid queue down the line. There are lots of community programs – many with wait lists – state and federal funds but not Medicaid funding. I am not saying create a Medicaid version of this, but know that the longer they go without this, the closer they come to being poorer and sicker and then eligible for Medicaid. Second, a long term solution will not happen in one budget year. To supplement care for caregivers and build a community based system you need more than one year, be sure we have in RI what will keep all of us healthy and with quality of life. Finally, in looking at those budget dollars, we receive less than $400K per year to take care of dozens of patients, with Alzheimer's, dementia other areas. When you talk about pulling savings out through investment, as a tax payer once that money is taken out and saved in some way, I don't feel it is owned by Medicaid. Yes put some into an incentive program, but how about putting some of it back into a community based system that would help all Rhode Islanders age with quality of life and dignity."
d. Rebecca Kislak, RI Health Center Association: "Our community health centers provide primary, behavioral, dental health services to 151K patients, including 81K in Medicaid. The CHC in the state are important partners in ensuring enrollees access to achieve best health outcomes possible. We submitted comments earlier today, I have a bunch of copies with me today for the working group members and the public for anyone who would like them."
e. Vinny Ward, home care services in Woonsocket –"The electronic verification issue I hear of today deals with plusses or minuses for home care. I feel that will be hundreds of dollars of cuts. I haven't asked all my CNAs if they have a smart phone, or if they can afford the minutes to call in care. It just keeps going up, wages in home care have

been stagnant, less and less of a magnet for careers then, EVV is another cost to an agency and cost to a CNA without raises."

IV. Adjourn:

a. Secretary Roberts: We have received a lot of recommendations over the last two days and we will do our best to get those reviewed and out there. Really want to remind folks we have the next phase: yes have it done by May 1, but we have another opportunity for a more in depth, bigger picture of where we want to go, you will see some of that laid out in the report next week. You are aware with many of the pieces of that system. Going to lay that out, by July 1 in more detail. Meeting again next Thursday, April 30. I do want to tell you, we have just today moved the time of that meeting to 2pm. It was originally 4pm, I apologize to all, that is a busy time of year and we have legislative issues to manage that day, thus this adjustment. Work Streams keep meeting, keep discussing. We have these ideas, but it is of critical importance to me that we also implement these ideas and get them done. Shared mission, do it best when do it together. Legislative partners also important. July 1 deadline to get big picture planning done, and then not just a plan but a map of how to get this done in the next four years. This was very different, but very informative for all of us.
b. Dennis Keefe extended gratitude to the group and consultants on behalf of Dr. Wilson and himself. Adjourned the meeting.